APPEAL NO. 93145

At a contested case hearing held in (city), Texas, on January 29, 1993, the parties stipulated that appellant (claimant) had sustained a low back injury in the course and scope of his employment with (employer) on (date of injury). The hearing officer, (hearing officer), determined that while claimant continues to have disability from such injury, he did not sustain a compensable neck or left shoulder injury on November 8th and that he reached maximum medical improvement (MMI) on November 16, 1992, pursuant to the report of the doctor designated by the Texas Workers' Compensation Commission (Commission). In his first and amended requests for review, both filed timely under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-6.41(a) (Vernon Supp. 1993) (1989 Act), claimant essentially challenges the sufficiency of the evidence to support the two adverse determinations. The respondent (carrier), in its response, urges our affirmance of the decision below.

DECISION

Finding the evidence sufficient to support the hearing officer's findings and conclusions, we affirm.

Claimant testified that while working on stilts as a drywall finisher for employer on (date of injury), he tripped over some studs on the floor and fell to the floor striking, sequentially, his buttocks, left shoulder, and the left side of his head. After resting for about one-half hour, claimant resumed working and finished the job. He prepared an accident report the following Monday and continued to work until sometime in February 1992 when his pain became so severe he was forced to stop working. He said he has not worked since that time because of the excruciating pains in his back and legs, upper body, and neck and left shoulder, and also mentioned that he could not perform his work when "all doped up" from his pain medication. Claimant stated that on November 14, 1991, he commenced conservative treatment for his back injury with (Dr. M), an orthopedic surgeon, and he continued seeing Dr. M until August 9, 1992. He then sought another doctor because he said Dr. M was only concerned with his lower back injury, told him he could not do anything more for his back, and felt his other problems (left shoulder, neck, head, and legs) were not a part of his injury from the fall. Claimant said he was not currently treating with any doctors because they all "seem to fail to recognize the problems."

On his Employee's Notice of Injury or Occupational Disease and Claim for Compensation, dated February 18, 1992, claimant stated the nature of his injury as "lower back." He said he did not immediately realize after his fall that he was in trouble with his shoulder and head. He acknowledged his neck had been hurt in a 1988 auto accident but contended that injury was to a different part of his neck. He testified that on February 10, 1992, he told Dr. C, to whom he was referred by Dr. M for another opinion, about his neck and left shoulder problems. He said that his head and neck began to hurt severely on February 13, 1992, and that Dr. M told him such pain could be attributed to a February 12, 1992 myelogram procedure. He acknowledged that Dr. M does not feel his neck and

shoulder problems are a part of his injury from the fall. While his first position was that his "upper pains," i.e., left shoulder, neck, and head, were attributable to the fall but that he did not realize at first the extent of his injuries, claimant's alternative position was that such were injured in the administration of a myelogram he underwent during the course of the treatment of his back injury and, therefore, qualified as part and parcel of his compensable injury.

Though not a part of the disputed issue concerning the extent of his work-related injury, claimant also testified that his right calf was injured on or about February 1992 during a physical therapy (PT) session when he performed a back exercise. He had pressed his back up against a wall and when he attempted to bring his buttocks into contact with the wall, he felt excruciating pain in his legs. Claimant also said his left thigh was injured while on the PT table on or about March 9, 1992. These leg injuries, claimant maintained, led to his July 1992 surgery for varicosities in his left calf leg and to his need for similar surgery on the other leg. According to claimant, Dr. M told him his leg problems were not part of his job-related injury so he had to get the surgery done outside the workers' compensation system. Claimant wanted the hearing officer to consider his leg injuries as a part of the disputed issue concerning whether he sustained an injury to his neck and left shoulder on November 8th; however, claimant made no effort to enlarge the issue pursuant to the provisions of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 142.7(d) (Rule 142.7(d).

According to Dr. M's records, when claimant was first examined on November 14, 1991, he gave Dr. M a history of receiving a whiplash type injury to his cervical spine in a 1988 auto accident, together with "chips in the neck." Dr. M diagnosed acute lumbar strain. A later MRI exam showed degenerative changes at the L4-5 level with a grade II posterolateral herniation of the nucleus pulposus (HNP) causing direct contact with the right L5 nerve root. When claimant saw Dr. M on November 19th they discussed the likely need for a surgical decompression, claimant indicated he wanted a second opinion, and Dr. M encouraged him to obtain one. Dr. M's notes of February 7, 1992 reflect that claimant had some "flare ups" with significant pain in the low back which radiates across the low back but not distally. They again discussed the probable need for a decompressive laminectomy and claimant's desire for a second opinion.

Claimant was seen on February 10th for a second opinion by (Dr. C), an orthopedic surgeon. According to Dr. C's records, claimant complained of low back pain on both sides with some pain radiating into the upper back and right buttock area, and of some tingling on the right side. Dr. C noted that the MRI revealed degeneration of the L4 and L5 discs with a right posterolateral HNP and contact between the disc material and the L5 nerve root on the right side. Dr. C agreed with Dr. M that claimant should undergo a myelogram and decide on surgery depending on the results.

Dr. M had claimant admitted to a hospital for a myelogram and EMG, and for a decision as to whether to proceed with surgery. According to Dr. M's notes of February

12th, the EMG revealed no nerve root involvement. Dr. M and the neurologist who performed the EMG both felt claimant "does have at least a bulging disc, if not a ruptured disc," as confirmed by MRI, but both also felt that in view of the negative neurologic exam, conservative treatment was indicated for several months before proceeding with surgery. On February 25th, Dr. M noted that the "horrible headache" claimant has had since his hospital discharge was improving and Dr. M recommended he start on a PT program three to five times a week for several weeks, then move into a work hardening program. On April 24th, claimant complained to Dr. M of his right leg swelling, and of a burning sensation on the left (back) and sharp, excruciating back pain, and surgery was again discussed. On May 27th, claimant still had a burning sensation on the left side of his low back, and occasional sharp, severe pain in the center of his low back. He also complained of right leg swelling. Again, claimant desired to continue with conservative treatment.

After seeing Dr. S, a family practitioner, on June 6th about his legs, claimant was seen on June 12th by (Dr. Z), a vascular surgeon, about his complaint of leg pain. Dr. Z reported that claimant had some superficial varicosities in the left thigh but that most of his large varicose veins were in the right leg. According to Dr. Z, the basis for these varicosities was "sapheno-femoral insufficiency." On June 17th, Dr. M advised claimant that his leg vein problem was not related to his doing exercises and that he needed to make up his mind within a month or two as to what he wanted to do about his back.

On September 9th, Dr. M noted claimant's continued low back pain radiating to his right leg, and continued numbness and tingling in the right foot. Claimant had veins in his right calf surgically removed on August 19th, had not improved, and intended to have similar surgery on his left leg. He also told Dr. M he had experienced problems with his neck since June 1992 and thought he hurt his neck in the fall. Dr. M said, "I pointed out to him that he had never mentioned his neck to me or anybody and he said it was probably because he didn't know he was having pain in his neck because he was on pain medication for his back." Dr. M's notes also stated: "I told this patient there really wasn't much I could do for him, that he needed to get himself organized and go find work. I don't think he could do drywalling right now because of his general overall condition. I told him I didn't think his neck was part of his original injury." None of Dr. M's records reflect discussion or treatment of a left shoulder injury.

On July 30, 1992, claimant was examined by (Dr. D), an orthopedic surgeon, at the request of the carrier. Dr. D signed a Report of Medical Evaluation (TWCC-69), accompanied by a written narrative report, which stated that claimant had reached MMI on July 30, 1992, with a five percent whole body impairment rating for his herniated lumbar disc with some residual pain. Dr. D noted no neurological abnormalities, a normal EMG, advised against surgery, and did not believe further conservative treatment would be of any help. A TWCC-69 signed by (Dr. K), the designated doctor, stated that claimant reached MMI on November 16, 1992, with a seven percent whole body impairment rating for his

lumbar spine. According to Dr. K's narrative report, claimant stated he fell at work and injured his neck and back, and complained "of a constant dull ache with sharp, shooting and stabbing pain in the neck and low back with radiation of pain into the left shoulder and arm and the buttocks, left thigh, right calf, foot and toes." Dr. K noted numbness and paresthesias in the left arm and the right calf, foot and toes. Dr. K's impression was that claimant's history and physical examination were consistent with herniated disc and intermittent sciatica in the past. He felt further diagnostic studies would have to be done to evaluate the cervical spine. A TWCC-69 signed by Dr. M stated that he agreed with Dr. D and with his five percent rating. Dr. M further stated he last saw claimant on September 9th and would use that date for MMI.

Still another TWCC-69, signed by (Dr. P), a neurologist, was introduced which stated that claimant reached MMI on September 9, 1992, with a five percent impairment rating. A letter from Dr. M, dated October 22, 1992, stated that, at claimant's request, he referred him to Dr. P for examination and treatment. Dr. P's TWCC-69 was accompanied by a narrative report dated January 6, 1993. According to Dr. P's report, which indicated he had the records of Drs. M, C, and D, claimant then complained of "burning" on the left side, low back, of left trapezius pain radiating from the left neck into the medial scapular area, and stated that the PT "created problems with both legs, varicose veins." Dr. P's impression was myofascial dysfunction, cervical and lumbosacral spine, asymptomatic herniated disc, L4-5, and MMI as of 9/9/92. He commented that claimant's symptoms "may represent latent nerve root compression by history as recorded in the chart but noted there was no evidence of a clinical radiculopathy at that time. Dr. P further commented that both Drs. D and M had set the date of MMI at 9/9/92, that based on his clinical exam there had been no significant change in claimant's symptoms, and that he could not therefore amend the MMI date.

The hearing officer concluded, based on a number of pertinent factual findings, that claimant did not sustain compensable neck or left shoulder injuries on (date of injury), and reached MMI on November 16, 1992, pursuant to the designated doctor's report. We have carefully reviewed the evidence and are satisfied it is sufficient to support these determinations. Article 8308-4.25(b) provides the designated doctor's report on MMI is to be given presumptive weight unless it is contrary to the great weight of the other medical evidence. Dr. K's report was consistent with the opinions of Drs. D, M, and P, all of whom reported that claimant had reached MMI. The hearing officer is the sole judge not only of the materiality and relevance of the evidence, but also of its weight and credibility. Article 8308-6.34(e). Where, as here, there is sufficient evidence to support the hearing officers' determinations, we do not substitute our judgment. Texas Workers' Compensation Commission Appeal No. 93042, decided March 5, 1993. Claimant's own treating doctor, Dr. M, explicitly expressed his opinion that claimant's neck complaints were not a part of his original injury from his fall at work and Dr. M's records do not reflect a left shoulder injury. While certain references to claimant's complaints of neck pain and to pain radiating into his shoulder area do appear in some of the medical records, such references do not reflect

opinions, aside from claimant's opinion, that his neck and left shoulder were injured in the November 8th fall.

Claimant's request for review is without merit and the hearing officer's findings and conclusions are not so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 751 S.W.2d 629 (Tex. 1986).

The decision of the hearing officer is affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Susan M. Kelley
Appeals Judge